STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 185389	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 7/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEMONT HEALTHCARE	**323 WEBSTER AVENUE CYNTHIANA, KY**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review it was determined the facility failed to ensure one (1) of fifteen (15) sampled residents (Resident #1) Minimum Data Set (MDS) assessment accurately refected the resident's status.

The findings include:

Review of Resident #1's clinical record revealed diagnoses which included Dementia with Behaviors, Chronic Renal Failure, Hypertension, and Cardiovascular Accident.

Review of the Significant Change MDS assessment dated 12/28/09 revealed Resident #1 was assessed by the facility as experiencing a fall in the past thirty-one (31) to one hundred eighty (180) days.

Interview with the Director of Nursing (DON) on 07/15/10 at 11:30 AM revealed Resident #1 experienced a fall on 12/16/10, however the assessment did not reflect the fall in the past thirty (30) days. The DON stated the MDS Coordinator at the time the Significant Change assessment was completed no longer worked at the facility. She further stated the 12/16/10 fall should have been reflected on Resident #1's assessment.

Plan of Correction for F226- (Dev/implementation of investigations)
Sample: R10

#1- R10 had investigation completed and appropriate officials notified as of survey exit. Policy/procedure applied to R10 as of compliance date in addition to facility performed in depth investigation according to policy after he informed facility of missing money and even had police officer come to facility to investigate in addition prior to survey exit (initiated after 7/7/10 as prior to that time resident was satisfied after money noted between bedrails and returned then changed to other allegations and was not alleged on dates as noted in 2567). Officer shared that R10 had changed story multiple times within minutes and was upset about family and no further investigation was warranted due to resident's statements of facts. OIG was informed during survey of issue as of 7/13/10 in addition by both resident, facility investigation report, and police officer. No further incidents have been reported after this episode and facility has adhered to its policy/procedures as of survey exit. No findings were substantiated for changing allegations after ongoing investigation was initiated again during survey, and has no change in outcome Admin, police, etc were unable to be substantiate due to information constantly changing regarding amount, details, and amounts matching up to what resident had on person after major purchases. Staff member would have been removed if resident had presented information given at much later time as he had no issues with staff for days, and then became outraged with no credible information to even remotely be considered as true, and other witness questioned immediately after resident threatened with fist to staff member (approx. 4 days later vs. that day it supposedly occurred). Administrator did not do formal 5 day report as it was verified no money was even possible to be taken as family did not bring in any, facility gives out money and also does purchases for resident, but did a thorough investigation which included witness statements to document behaviors, in addition to information constantly changing and then resident threatened us with "this is not over and I want my money, even though it is in our policy regarding not refunding any monies if kept on person vs. allowing facility to keep in lock box at nursing station, then resident said to drop it when informed of ability to inform Ombudsmen, Police officer, etc,. R10 did not wish for us to pursue but then initiated all over when survey team was in building and facility requested for officer to come and speak with survey team in addition. Facility does remove staff during any investigation until (FYI- after police spoke with survey team and investigation of all witness statements and revealing purchases, etc. facility was informed that everything was ok, then found deficiency in place upon survey exit, again- we investigated/documented, etc to reveal absolutely no truth to allegation at the very onset and situations that existed on this delusional /manipulative behavior due to anger with family and major money investment for outing that was cancelled.)
** Needed to explain situation for outcome of allegation and Policy Regarding Money Handling

#2 All residents have potential to be affected by said practice, but no additional investigations/reporting required as of this date after Admin/SS Director reviewed grievance reports and speaking with residents at resident council meeting on 7/28/2010 and no other residents have been affected by said practice. Will utilize current Policy/procedure for initiating/prevention of alleged allegations of misappropriation of funds according to state/Federal guidelines and was reviewed by medical director in addition at QA meeting as described below with no further suggestions for changes at that time.

#3/#4- Facility has conducted a resident council meeting on 7/28/10 by SS Director and Ombudsman to discuss if residents had any concerns which needed reporting, discuss importance of giving accurate information promptly, safest place for money storage, and reviewed resident rights again as previously held just a couple months prior to survey in addition. No residents had issues at that time regarding this concern and voiced understanding of facility policy regarding trust funds held and facility's responsibility to safeguard money, and if not given to facility to hold then no refunds of any monies lost/missing shall be replenished, even after being investigated/reported.
Additional Inservices Include: 7/16/10 for policy/procedure of reporting any grievances voiced or witness to any potential issues regarding reporting requirements to Department managers given by Admin. Consultant/Administrator. General all staff including Nsg Staff inserviced again on 7/29/2010 in addition to memo/policy for suspected allegations of abuse/neglect/misappropriation of funds and reporting requirements per policy to Supervisor/Manager on Duty during evening and weekend hours (which includes follow initiating and reporting within 24 hour period with 5 day follow up to findings to appropriate agencies). Resident Rts/Belonging and grievances again given by Ombudsman/SS Director on 7/28/2010. Additional information/policy inservice/discussion occurred on 8/3/2010 at QA meeting for remaining supervisors/Medical Director.

Policy/Procedure remains in place for investigation/reporting. Administrator (relatively new to skilled LTC) was educated by Admin. Consultant re: requirements and that what she initiated was an investigation and that explanation to surveyor was inaccurate/misleading and appeared as though facility failed to perform accordingly. Facility does remove staff when an investigation is in progress, but resident did not report misappropriation of money after telling nurse, who after finding in bed/returning money to resident, did not accuse staff of taking until days later. Will continue to follow policy/protocol for implementation of investigating/reporting when appropriate.

Department managers were inserviced on 7/16/2010 by Admin/owner regarding Investigating/reporting requirements for allegations of misappropriation of funds/neglect; state/federal requirements including time lines, policy and grievance forms. General all staff/including nursing staff in-serviced on 7/29/2010 (which is done on regular basis) Resident council meeting held on 7/28/2010 by SS Director and Ombudsmen regarding importance of proper reporting/ best solutions for money handling/Resident rights...

Grievances requiring reporting/investigation shall be initiated within 24 hours per guidelines, staff responsible shall be removed after informed of allegation until investigation completed, and 5 day follow up for suspected/confirmed allegations of abuse/neglect, etc shall be documented and documentation shall be forwarded to appropriate agencies accordingly.

Grievances/complaints shall be discussed at morning clinical meetings at least 3 times weekly times 90 days and any requiring investigation with reporting requirements shall be discussed/reviewed by Admin and Executive Director on weekly basis times 90 days to assure policy compliance. Grievance logs shall be reviewed by Administrator on at least a weekly basis times 60 days in addition and shall document on QA form any noted concerns/grievances not followed and shall notify Admin/CEO for additional oversight for additional checks/balances and assure proper investigation/reporting requirements fulfilled.

QA mtg conducted on 8/3/2010 with key dept managers, medical Director and Executive Director which included policy, informing Managers of requirements, and POC compliance. Shall continue with weekly QA (with auditing) and include with monthly QA times 90 days.

Date of Compliance: 8/4/10 (for inservicing and QA purposes)
SS Director and Administrator responsible for compliance

PLAN of Correction for Ftag 241- Dignity/Respect—Privacy/knocking
Sample: General and observation of #2

#1 &#2--- Both R2 and other alert/oriented residents have been addressed regarding rights to have others assure privacy by knocking and were informed at resident council meeting on 7/28/2010 by SS Director and ombudsman and to report any non-compliance by staff/others if not knocking on doors prior to entry in addition to staff inservices, as described below, to assure privacy/knocking prior to entering rooms. QI members (department managers are checking to assure while performing dly rounds) that staff/beautician, etc are knocking prior to entering rooms as well (see below for details). All residents have potential to have privacy/respect issues affected by said compliance, and no further complaints reported or other residents affected regarding said practice after interviews conducted/resident council meeting held to question residents concerns including resident right's repeated and need to report to administration when incident occurs for follow up (as resident's had not previously brought up in other council meetings or interviews with ombudsmen or SS director prior to survey nor after with 7/28/10 meeting).

#3 &#4- Employees identified in 2567 in addition to General all staff (nursing, housekeeping, laundry, dictary, Maintenance, etc) were in-serviced on 7/16/2010 and again on 7/29/2010 regarding importance of monitoring for wandering residents, assuring dignity/privacy by knocking on doors and reiterating resident rights by

Administrator/Executive Director. Beautician inserviced along with dept. heads as of 7/20/2010 regarding requirements of knocking/dignity/respect by Administrator/designee.

QI responsibilities to monitor/remind staff/residents to knock before entering rooms if note any non-compliance and shall be monitored/documented on QI forms at least 3 times weekly times 90 days. Any noted concerns shall be included with weekly clinical meetings to address need for additional training/monitoring. Requirements/concerns discussed at 8/3/2010 QA meeting and shall continue to review compiled QA weekly meeting/QI rounds forms to assure ongoing compliance and if additional interventions are required. Act Director/designee shall document concerns at next monthly resident council meeting to be in August in addition to one held on 7/28/10 to assure staff are complying. R2 and other residents denied any ongoing problems at that time but will continue to monitor (R2 does have attn seeking behaviors and also have delusional/poor decision making abilities which are also taken into consideration when resident makes dly unrealistic other demands). Nurses reminded to supervise at in-services above to have night shift nurses assure compliance in addition to administrator who shall monitor both shifts at least weekly times 30 days.

Date of compliance: 8/4/2010
SS Director/Administrator responsible for compliance

Plan of Correction for F276- Quarterly Assessment Completion Sample:,R5, R11, R13, R14

#1 & #2- R11 had MDS printed off day of exit as was already entered/completed, and just needed placed in chart, R13 has had MDS completed timely as of 5/17/10 and ongoing as of 8/28/10 R14 had MDS completed timely since 3/28/10 and thereafter as of compliance date. R5 was completed as of 7/10/10 and available as CPC team at a MDS 3.0 conference that week but was still completed by RN consultant but waiting for CP team to review for accuracy/conference, but then state/federal survey began following week. Information was completed as of survey exit, but again was not available in chart for review and placed in chart on 7/16/10 - all had MDS completed as of this date and completed as stated above. *please note that R14 had additional MDS done on 12/28/09 in addition to 12/08/09 which state of KY accepts for regulatory requirements and was done on 12/28/09 for Medicare 30 day (explains why 3/28/10 was next assessment) and was discharged as of 6/2010. R11 did have MDS completed but was not available in chart during survey week (was out to finish care plan) but was entered/sealed in computer during survey. R13 was done late as new CPC had wrote down wrong date for completion based on the protractor system (as described under Ftags 287 and F520) that was not accurate and was an isolated incident, but now CPC assures to check from both business office computer generated reports and hand written calendars for due dates. Information was gathered/entered into computer as of survey exit, but again was not available in chart for review. DON/designee have reviewed all MDS due prior to 8/28/10 to identify additional residents out of compliance/other concerns and residents have had MDS completed and shall have transmissions completed by 8/28/2010.(See below under #3 for additional monitoring to assure ongoing compliance)
CPC/DON had just attended required MDS 3.0 training from July 6-9th for upcoming regulatory changes just prior to entrance for State/Federal survey, and was unable to answer questions regarding specifics for due dates, even though calendar was offered to show when MDS due dates were/are, but was not taken into consideration. Facility did acknowledge that ability to transmit was late and we were doing our best as explained in 2567 as MDS had to be compared to business office before transmitting them to avoid false information being billed ,etc. 2 of the possible unknown sampled residents were noted to have late assessment that was due around 2nd week of July that coincided with survey/after seminar and have been completed as of this date. No residents were adversely affected by said practice as after completing MDS there were no significant changes for ones noted to be not available within the 92 day time frame nor had any changes required to care plan that would have impacted residents.

#3 &#4- Executive Director/CPC and/or designee will continue to review all MDS due that month to assure that quarterly assessments have been completed on timely basis by comparing both computer generated due date schedule to last assessment completion date and MDS hand written calendar on at least a bi-monthly basis for at least 90 days. Then monthly thereafter times 6 months, to assure compliance.

Facility has contacted Accu-med and computer technician to assure "gateway from MDS, transmissions, and business office" continues to properly carry over information in addition to comparing completed MDS to Business office coding for assuring both completion/accuracy/and transmitted information matches up for Regulatory requirements. Computer Tech. and Accumed software companies remain on retainer and paid monthly for ongoing services/support to assist with compliance which was identified and have been diligently working on fixing multiple complicating factors in addition to adding/removing diff. components causing modem/transmittal problems as well as program not running well on MDS computer and shall be maintained by front business office to print off reports to be given to administrator/designee for monitoring as well as CPC for cross checking until assured accuracy to avoid need of hand written schedules as well.

MDS nurse/clinical team dept managers were inserviced as of 7/20/10 regarding assuring timeliness of MDS completion, transmitting requirements to be changed prior to date of compliance to at least a bi-monthly basis, RAI/Care plan process given by Administrator. In addition IDT team discussed issues/possible resolutions at QA meeting held on 8/3/10 to implement additional system changes to assure audits being performed, having both hand written schedule in addition to computer generated schedule to compare for inaccuracies to have software vendor and computer technician to correct, which another issue identified as causing problems in addition to virus, 'Gateway interface from MDS to business office", etc. was attempting to prepare for the new MDS 3.0 and was downloaded on computer early to assure will be ready for transformation when MDS 3.0 takes effect in October.

In addition to 8/3/2010 QA meeting which included deficient practice and discuss other possible complications, resolving current issues and auditing for compliance with both IDT team and Medical Director/Administrator present, facility will perform monthly formal QA meetings times 90 days to assure ongoing compliance, auditing performance and also to prepare for MDS 3.0 transformation. Information shall be discussed regarding findings of audits, MDS completions with transmissions performed for that month to correlated with MDS completed/due by Executive Director/designee in addition to CPC

CPC responsible for compliance
Date of compliance: 8/28/10 to assure computer software/tracking tools effectively working

Plan of Correction for F280- Right to participate in Care planning
Sample: R1, R2

#1 and #2- R1and R2 has had comprehensive care plans reviewed/updated accordingly ongoing as needed as of 8/28/10 by IDT team to assure revisions, risk factors, interventions, etc have been included for staff review. R1 has had no additional issues from said cause factors and R2 wound was noted on 7/5/2010 and was already healed prior to survey exit on 7/15/2010. All residents have potential to be affected by said practice, but no other residents were affected from said practice as care plans reviewed by both state surveyors and also care plans due after exit date have been reviewed/updated with MDS completion, changes in status, etc with weekly clinical meetings along with assuring esp. that interventions for falls/skin breakdown and other QI changes have been being addressed as they occur on at least a weekly basis and any resident with above stated changes in condition/QI changes by clinical team as of compliance date and ongoing weekly thereafter. In addition, no other resident has been adversely affected by said practice as information regarding skin care, fall risks, etc are also located in TARs, on 24 hr clip board with QA "action team minutes discussing residents like R1, R2" for staff to review suggestions , skin assessments, etc for additional information to formal care plans and evidence by staff answering questions re: cause of falls for R1 and wound healing on R2 prior to survey exit (approx. 1week timeframe). For R1- It was also determined that the matt put in place could not be utilized until 6/28/10 as it would have increased risk of fall hazards/tripping and only option after resident stopped getting out of bed due to inability. R1 also refused body alarms, therapy and facility did attempt to provide every possible intervention including clearing out items in room immediately, but would trip over other resident's in Dining room (refer to F323).

#3 Care plans shall be updated/reviewed with RAI process as noted when due on calendar for completion as well as when a significant change in condition is identified as noted above with weekly clinical meetings by clinical team at a minimum.
Inservices:IDT in-serviced on 7/20/10 by Administrator/executive director re: importance of RAI and Care Plan Process, Auditing requirements, need for resources regarding changes/orders etc available to CPC and information to be covered in weekly clinical/care plan meetings including checking in addition to QA meeting sharing information on 8/3/2010- Reviewing RAI guidelines for RAI completion, assessment completion/accuracy of MDS information readily available, using MDS information to complete individualized care plan and references when specific information located elsewhere. "To Do List" given to all dept. managers regarding interventions mentioned with QA form to use for summarizing issues as of compliance date.

Will continue to update MDS, RAPS, and care plan as MDS due until all residents completed times 90 days. Shall update/review thereafter with quarterly MDS schedule for individual residents and as needed with change in condition ongoing.

#4- IDT(Care Plan team) shall meet on a weekly basis to include at a minimum the following information: pertinent items in 2567 (times 90 days) such as: audits due as described above and other quality indicators. Concerns re: compliance will be documented on QA form/Audit form and staff shall be re-inserviced or receive disciplinary action if non-compliance continues. QA meeting held 8/03/10 to include information regarding survey (this was performed early to focus on system protocols and prevention, and outcomes shall be discussed with next scheduled regular QA meeting, QA shall return to quarterly basis with ongoing clinical meetings that discuss Patient care concerns, Quality indicators in addition to formal QA meetings

CPC responsible for compliance
Date of compliance: 8/28/2010 to assure additional care plans continue to be addressed.

Plan of Correction for F287- Encoding/Transmitting assessments
No Sample- utilized provided Transmittal records found in binder
(All requirements for answers comingled since regulatory issue not affecting sample residents)
Multiple residents have been identified as having MDS transmitted past 30 days of completion date and facility has set up manual system (due to both computer problems and software issues affecting accurate transmissions of MDS but are being accepted by Meyer/Stouffer and state at this time for timely completion, except those 3 sampled under quarterly assessments, but have still shown as late for transmitting purposes even after survey exit d/t having to triple check to assure MDS is matching billing/RUG classification prior to submitting information, and shall continue to be worked on by both computer technician and software vendor- and MDS shall be caught up with timely transmissions and ongoing thereafter as of compliance date 8/28/10. Facility has recently changed computer technician company after virus issues made computers crash as other computer company was not fixing computer problems/unavailable to be reached, in addition to ongoing calls to have Accu-care software company working out issues that "Gateway internet" from MDS processing to business office information is fixed. Facility is also removing a program (pro tracking system) that was installed on MDS computer for QA purposes last fall (to show QI indicators/auditing for MDS completion) which will be replaced on business office computer to avoid interferences and for auditing compliance of completion/transmitting of MDS as of compliance date. This program shall be moved to business office and updated which shall allow auditing be done on bi-monthly basis by CEO/designee) ongoing to check for compliance of transmitting information. In addition to computer generated schedule, MDS nurse shall continue to hand write on calendar for residents due dates based on last completed/admission, etc. for additional checks/balances.

No residents have been affected by said practice as MDS completed as of survey exit, and remaining issue is about transmitting information only. MDS have been completed per guidelines and placed in chart as of this date. *note- facility did not have that many transmitted late as mathematically unable based on census and number of MDSs due compared to transmission reports and as part of QA to identify failure of transmitting which was done on monthly most of last quarter of 2009, and then assured everyone was transmitted at least quarterly for 1st quarter of year (as noted in 2567) which were kept in different binders as change in position occurred and all reports not given to survey team at time of survey to show that facility has audited for outstanding/noncompliance.

MDS nurse/clinical team dept managers were inscrviced as of 7/20/10 regarding assuring timeliness of MDS completion, transmitting requirements to be changed prior to date of compliance to at least a bi-monthly basis, RAI/Care plan process by both consultant/and Administrator. In addition IDT team discussed issues/possible resolutions at QA meeting held on 8/3/10 to implement additional system changes to assure audits being performed, having both hand written schedule in addition to computer generated schedule to compare for inaccuracies to have software vendor and computer technician to correct, which another issue identified as causing problems in addition to virus, 'Gateway interface from MDS to business office", etc. was attempting to prepare for the new MDS 3.0 and was downloaded on computer early to assure will be ready for transformation when MDS 3.0 takes effect in October.

In addition to 8/3/2010 QA meeting which included deficient practice and discuss other possible complications, resolving current issues and auditing for compliance with both IDT team and Medical Director/Administrator present, facility will perform monthly formal QA meetings times 90 days to assure ongoing compliance, auditing performance and also to prepare for MDS 3.0 transformation. Information shall be discussed regarding findings of audits, MDS completions with transmissions performed for that month to correlated with MDS completed/due by Executive Director/designee in addition to CPC.
*Note: QA /facility has been addressing problem since last fall, and is why new software purchased, change in computer technicians, new computers purchased, implemented checks and balances to assure appropriate billing as well, etc even prior to survey and information was given at that time. Facility was also proactive and notified both Medicaid and Myers/Stouffer to inform of difficulties and get suggestions and also do as an FYI prior to survey visit but has had multiple complicating factors including lasts downloads of MDS 3.0 software onto computers as well as modem difficulties, freezing up, etc even after thousands of dollars in attempted repairs/support assistance.

Date of compliance: 8/28/2010
CPC responsible for compliance

Plan of Correction for F323- Free of Accident hazards/Supervision Sample R1

#1 and #2- R1's environment/room was remedied prior to survey exit and other then falling from side table (which was moved to foot of bed right after fall)- other falls were from getting up unassisted and tripped over other residents in dining room area (right across from room) which staff were aware of resident's noncompliance, impairments and staff would provide extensive assist with providing weight bearing support in addition to encouraging resident to grab a hold of hand rails after finding her out of room. (Extensive asst is confused by staff but they admitted to assisting resident back to a chair/room, etc). The Care plan still contains wording to supervise when up and walking to alert them to monitor d/t non-compliance and provide oversight since resident refuses body alarms, not good candidate for restraints, and was originally placed near a common area next to Nsg office for additional supervision and many falls occurred right in front of staff from resident being "too quick" prior to survey. Once another room became available- and resident no longer able to get up unattended is when room change occurred and also a mat could be placed at bedside as it was no longer a tripping hazard after return from ER. R1 had already been assessed as described in detail for vision, behavioral, physical, cognitive, etc impairments. Facility requested PT screen, then placed on restorative program for strengthening endurance/gait, pharmaceutical review of medications and other possible solutions which included staff oversight in addition to assistance as resident required both due to her non-compliance and inability to comprehend surroundings and would become combative so other interventions included as well to assure safeguarding i.e. use of handrails while staff assisted as much as she would allow to prevent further injury. Now that R1 is no longer able to get up unattended, additional interventions effective at this time. Housekeeper, new to LTC but was informed of protocol was responsible for leaving cart while in resident's room and was immediately notified prior to survey exit of issue with leaving cart unlocked and no other carts have been identified for affecting said practice while performing daily QI rounds to check. No other residents also affected by said practice of hazards from falls as clinical reviewed falls to check for patterns/care plans to assure said practice is in compliance.

#3/#4 Policy for both falls, environmental hazards, and care plans for residents with having falls from any environmental issues were assessed by clinical team and reported to QA team 8/3/2010 of any additional concerns found. Policy was reviewed by team and Medical Director and shall remain in place at this time. In addition, DON

reviews all incident reports and 24 hour report on regular basis and no further incidents have occurred regarding same incident as R1.

Incidents/Accidents are reviewed by DON and Admin with daily stand up meetings. Administration will address each incident according to circumstances as they occur, possible cause, and implement interventions/assure care planned to help prevent reoccurrence accordingly. QI rounds (performed at least 5times weekly by QI Dept.manager shall include monitoring for unsafe environmental concerns and will be discussed/included on QI rounds sheets on day performed if noted for all designated Dept. manager to address with responsible staff in addition to informing staff if they notice any concerns at that time. This information shall be included with scheduled QA meetings times 90 days.

In-services given: Department Heads (QI members) inserviced by administrator on 7/16/2010 in addition to 8/3/2010 at QA meeting regarding requirements for care plan updating, environmental concerns, Housekeeping carts, Care plan update to include high risks for incidents. CP team informed at same time regarding audits, weekly clinical documentation for QA in addition to 7/20/2010. Housekeeping staff inserviced on 7/16/2010 and repeated on 7/29/2010 in addition to noted employee regarding safeguarding chemicals and responsibilities for assuring environment free of unnecessary equipment, free of hazards, etc. Nsg/and other general all staff meetings held on 7/29/2010 to cover both supervision of resident's with fall risks, following care plan/updating accordingly, and also to assure environment free from hazards. Nursing staff had additional inservice that day regarding importance of identifying cause factors for falls, supervision/documentation to assist with taking credit for oversight provided after incidents occur, and noting issues on 24 hr report for addjtional monitoring/notifying next duty staff of situations/concerns.

Non-compliance with audits, incidents without proper intervention, and other interventions noted in POC shall be communicated to administrator. Audits, incidents, QI rounds concerns, etc. shall be discussed at monthly QA times 90 days to assure compliance in addition to weekly clinical meetings addressing issues. First QA meeting conducted on 8/03/2010.

Date of compliance: 8/12/2010
Housekeeping Supervisor Responsible for General Environmental Hazards and DON responsible for compliance for Accidents/Audits/Interventions

Plan of Correction: Ftag 371- Food Procure/storage/Serve
No sampled residents

#1- All areas as noted in 2567 have been cleaned/corrected as of compliance date by dietary staff and manager including wearing hair nets appropriately, proper hand washing techniques, and changing gloves, scoops now placed in containers to prevent improper handling of utensils, and dented cans stored in separate location b4 being returned to vendor. Ongoing weekly "audits by other QI members performed in addition to Dietary manager/dietician" to assure compliance maintained for all the above and documented on inspection form which is given to administrator for review.

#2- No other areas identified as facility only has one kitchen and audits/inspections include checklist of additional sanitation concerns in addition to ones noted in 2567 completed by Dt manager, dietician, designated QI Dept heads monitoring for hand washing, hair nets, food/utensil storage and noted on audit forms as of 8/3/10. No residents have been adversely affected by said practice as evidence by no outbreaks in illness, and no additional issues noted after 1st day of survey as dietary manager addressed concerns prior to 2nd day of survey.

#3- Cleaning schedule updated by dietary manager and reviewed by Administrator as of 7/30/10 along with discussion at QA meeting held on 8/3/10. Dietary manager to assure cleaning schedule, cans/foods separated, scoops stored properly in new containers, and monitoring tray line for appropriate hand washing/change of gloves- general sanitation requirements being met. Assigned Dept managers to perform inspections on at least weekly basis in addition and document on inspection check list of performing audit/and shall note concerns for administrator/Dt. manager to address and reinservice accordingly times 90 days. This information shall be included with 8/3/10 QA meeting as well as other scheduled QA meetings times 90 days.

Dietary staff in-serviced on 7/16/2010, 7/20/10 by Dietary manager as well as on 7/29/2010 by administrator which included information regarding cleanliness, hand washing, hair nets, proper utensil handling and storage, Food prep, proper dishwashing procedures, other duty responsibilities, and all issues as noted in 2567.

QA Information: pertinent items in 2567 such as: audits due as described above and other quality indicators. Concerns re: compliance will be documented on QA form/Audit form and staff shall be rein-serviced or receive disciplinary action if non-compliance continues.
QA meeting held 8/03/10 to include information regarding survey (this was performed early to focus on system protocols and prevention, and outcomes shall be discussed with next scheduled regular QA meeting, QA shall return to quarterly basis.

Dietary Manager responsible for compliance
Date of compliance: 8/4/10

Plan of Correction for Ftag 441- Infection control- Handwashing
Sample: R4

#1 & #2- As R4 is combative with care at times, nurses have been assuring that other nursing personnel are present (as nurse informed that OIG not allowed to assist during care) when providing wound care/other ADL care accordingly as of survey exit. Nursing staff have been adhering to hand washing per observations by nursing mangagement/QI members. Multiple in-services given regarding importance of infection prevention/hand washing (see below for details). R4 has had no complications from said practice based on wound results. All residents have potential to be affected by said practice. No residents affected as of compliance date by monitoring infections/common bacteria reports from labs, etc. (R1 Nurse has been counseled regarding said practice and explained to assure that additional staff are present to assist and was educated regarding that surveyors are not to interact for assist as she is new to survey process as of 7/20/10).

#3 &#4-
Multiple in-services given to address hand washing/infection control per policy. R1 nurse specifically educated regarding non-compliance as of 7/16/10 as well as Inservices given by Administrator and Nursing Management to nursing staff (nurses/CNAs) on 7/16/10, 7/20/10, & General all staff on7/29/10. Information also shared via memo given with 7/30/2010 checks to multi departmental staff to assure staff understanding as taught with CNA/Nurse training. Hand washing/Infection Control policy importance discussed at meetings/memo.

In addition to in-services, QI members and dept. managers have been monitoring staff prior/after care of residents to assure/remind of hand washing in addition to glove use. DON/ADON informed by Administrator with QA mtg 8/3/10 as well to assure that staff are being monitored and to document any ongoing non-compliance issues on QA form to be discussed for additional in-services needed/monitoring.

QI members informed by Administrator/executive Director on 7/16/10 as well as with QA mtg on 8/3/10 that dept. managers need to monitor as well with QI rounds at least 3 times weekly and inform staff when noted to not wash hands per protocol and to inform Dept. Manager of non-compliance times 90 days.

QA Information: pertinent items in 2567 such as: audits due as described above and other quality indicators. Concerns re: compliance will be documented on QA form/Audit form and staff shall be rein-serviced or receive disciplinary action if non-compliance continues. QA meeting held 8/03/10 to include information regarding survey (this was performed early to focus on system protocols and prevention, and outcomes shall be discussed with next scheduled regular QA meeting, QA shall return to quarterly basis.

Nursing Managers responsible for compliance
Date of compliance: 8/04/10 to allow for additional in-services/assure monitoring

Plan of Correction for F520- QA committee
Based on Non sampled residents for General Transmitting system

Multiple residents have been identified as having MDS transmitted past 30 days of completion date and facility has set up manual system (due to both computer problems and software issues affecting accurate transmissions of MDS but are being accepted by Meyer/Stouffer and state at this time for timely completion(except 3 sampled as noted under FTag 276, but have still shown as late for transmitting purposes even after survey exit only d/t having to triple check to assure MDS is matching billing/RUG classification prior to submitting information, and shall continue to be worked on by both computer technician and software vendor- and MDS shall be caught up with timely transmissions and ongoing thereafter as of compliance date 8/28/10. Facility has changed computer technician company late fall after virus issues made computers crash as other computer company was not fixing computer problems/unavailable to be reached, in addition to ongoing calls to have Accu-care software company working out issues that "Gateway" from MDS processing to business office information is fixed. Facility is also removing a program (pro tracking system) that was installed on MDS computer for QA purposes last fall (to show QI indicators/auditing for MDS completion) which will be replaced on business office computer to avoid interferences and for auditing compliance of completion/transmitting of MDS which shall be done on bi-monthly basis by CEO/designee) ongoing. In addition to computer generated schedule, MDS nurse shall continue to hand write on calendar for residents due dates based on last completed/admission, etc. for additional checks/balances. No residents have been affected by said practice as MDS completed as of survey exit, and remaining issue is about transmitting information only. MDS have been completed per guidelines and placed in chart as of this date. *note- facility did not have that many transmitted late as mathematically unable based on census and number of MDSs due compared to transmission reports and as part of QA to identify failure of transmitting which was done on a monthly most of last quarter of 2009, and then assured everyone was transmitted at least quarterly for 1st quarter of year which were kept in different binders as change in position occurred and all reports not given to survey team at time of survey to show that facility has audited for outstanding/noncompliance.

MDS nurse/clinical team dept managers were inserviced as of 7/20/10 regarding assuring timeliness of MDS completion, transmitting requirements to be changed prior to date of compliance to at least a bi-monthly basis, RAI/Care plan process by both consultant/and Administrator. In addition IDT team discussed issues/possible resolutions at QA meeting held on 8/3/10 to implement additional system changes to assure audits being performed, having both hand written schedule in addition to computer generated schedule to compare for inaccuracies to have software vendor and computer technician to correct, which another issue identified as causing problems in addition to virus, 'Gateway interface from MDS to business office", etc. was attempting to prepare for the new MDS 3.0 and was downloaded on computer early to assure will be ready for transformation when MDS 3.0 takes effect in October.

Executive Director/CPC and Consultant will continue to review all MDS due that month to assure that quarterly assessments have been completed on timely basis by comparing MDS due that month on calender to perform to transmittal reports on at least a bi-monthly basis for at least 90 days. Then monthly thereafter times 6 months, to assure compliance.

In addition to 8/3/2010 QA meeting which included deficient practice and discuss other possible complications, resolving current issues and auditing for compliance with both IDT team and Medical Director/Administrator present, facility will perform monthly formal QA meetings times 90 days to assure ongoing compliance, auditing performance and also to prepare for MDS 3.0 transformation. Information shall be discussed regarding findings of audits, MDS completions with transmissions performed for that month to correlated with MDS completed/due by Executive Director/designee in addition to CPC as noted in above paragraph.

CPC and Administrator responsible for QA compliance
Date of compliance: 8/28/2010

PRINTED: 07/29/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185389	A. BUILDING _____ B. WING _____	C 07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEMONT HEALTHCARE	323 WEBSTER AVENUE CYNTHIANA, KY 41031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Standard Recertification Survey and an Abbreviated Survey investigating ARO #KY00014879 were initiated on 07/13/10 and concluded on 07/15/10. A Life Safety Code Survey was conducted on 07/13/10. The ARO#KY00014879 was found to be substantiated with deficiencies cited. Deficiencies were cited with the highest Scope and Severity of a "G" ".	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the facility's Policies and/or Procedures were implemented related to misappropriation of resident property. Resident #10 informed the facility of missing money and identified a staff member related to this however, the facility failed to implement it's Policy/Procedure retaliated to this allegation. The findings include: Review of the facility's Abuse Reporting policy revealed that the facility, "upon receiving a report of abuse, misappropriation of property, or neglect, the Administrator or designee will report the incident to the following agencies: Office of the Inspector General, Department of Community Based Services, and Law Enforcement Agency (If	F 226		

RECEIVED
AUG 11 2010
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Zech
TITLE: Administrator
(X6) DATE: 8-11-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	Continued From page 1 appropriate)." 1. Review of Resident #10's record revealed diagnoses which including Severe Right Hemiparesis, History of Severe Stroke, and Aspiration Pneumonia. Review of Resident #10's MDS dated 04/22/10 revealed the facility assessed the resident's cognition as being moderately impaired. An interview was conducted on 07/13/10 at 10:30 AM with Resident #10. Resident #10 stated Certified Nursing Assistant (CNA) #1 took $110.00 from him/her one week ago. When asked if Resident #10 made a report regarding the theft, the resident stated he/she spoke with the Administrator and the Social Worker, and he/she feels they "didn't do anything" [with the information]. The resident indicated the money was taken by CNA #1 after she had given the resident a shower and returned him/her back to resident's room. Resident #10 stated he/she witnessed CNA #1 take money from his/her (Resident #10's) wallet. Interview with the Social Worker on 07/13/10 at 12:05 PM revealed Resident #10 initially made a report about missing money, but did not report seeing any staff take the money. The Social worker stated Resident #10 made an allegation that CNA #1 took the money at a later date and not during the initial report. The Social Worker described Resident #10 as "very aware" of his/her wallet. The Social Worker did not know the status of the incident, stating the Administrator was handling the investigation. Interview with the Administrator on 07/13/10 at 3:55 PM revealed Resident #10 initially	F 226		

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F 226	Continued From page 2 complained about missing money after a shower on 07/03/10, and later that same day a Registered Nurse (RN) found $20 while searching for lost money in Resident #10's room. The Administrator reported this money was returned to Resident #10. The Administrator indicated on 07/05/10, Resident #10 stated CNA #1 had taken money from him/her. Given Resident #10's initial report about missing money, the Administrator indicated she considered this a matter for "inquiry" and not "investigation." The Administrator stated she interviewed CNA #1 on 07/06/10 regarding the missing money, and CNA #1 did not know about the allegation prior to the interview. The Administrator reported CNA #1 denied taking any money. Interview with the Administrator on 07/14/10 at 9:50 AM revealed an "inquiry"was an unofficial investigation to check a situation to see if it warrants an official investigation, but the same procedure was followed for both inquiry and investigation. The Administrator reported that as Resident #10 changed his/her story, it was not reported and CNA #1 was not removed from resident care pending investigation results.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to promote care for	F 241		

D of story or not the allegation is to be reported!

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F 241	Continued From page 3 residents in a manner which maintained or enhanced each resident's dignity, privacy, by failing to knock on the door or announce themselves prior to entering residents' rooms. The findings include: 1. Group Interview on 07/13/10 at 3:30 PM to 4:15 PM revealed one (1) alert and oriented resident of the seven (7) residents present stated there were times when staff needed to be reminded to knock before entering a room. The example given was if this resident had a visitor or was in the another resident's room, there were times when staff would enter without knocking. This resident indicated it infringed on his/her privacy. 2. Observation during tour on 07/13/10 at 9:45 AM revealed a housekeeper enter a residents room, Room 316, without knocking on the door before entering. Interview with the housekeeper on 07/14/10 at 3:45 PM revealed she forgot to knock before entering the resident's room. 3. Observation on tour, on 07/13/10 at 9:52 AM revealed the facility beautician enter two (2) residents' room, Room 321, without knocking on the door before entering. Interview with the beautician on 07/13/10 at 11:00 AM revealed she thought she had knocked. 4. Observation on 07/14/10 at 3:30 PM revealed the Maintenance Director enter a room, Room 204, without knocking on the door before entering. Interview with the Maintenance Director on 07/15/10 at 9:30 AM revealed he was aware that he was supposed to knock prior to entering a resident's room.	F 241		

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F 241	Continued From page 4 5. Interview with Resident #2 on 07/14/10 at 2:15 PM revealed staff sometimes came in her room without knocking on the door prior to entering.	F 241		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to conduct a comprehensive assessment within fourteen (14) days of admission for two (2) unsampled resident (Resident's A, and D). The findings include: 1. Review of the facility Minimum Data Set (MDS) Transmittal record for Resident A, revealed on 09/02/09, twelve (12) assessments were transmitted to the state data base; three (3) of these were rejected; and, one (1) initial assessment was transmitted more than fourteen (14) days after the resident admission date. 2. Review of the facility MDS Transmittal record for Resident D revealed on 09/11/09, eight (8) assessments were transmitted to the state data base with one (1) initial assessment was	F 273	Deleted	

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F 273	Continued From page 5 transmitted more than fourteen (14) days after the resident admission date. Interview with the MDS Nurse on 07/15/10 at 1:35 PM, revealed she and/or the owner transmitted the MDS assessments, and she was aware there were late assessments. The MDS Nurse stated the facility was having computer system problems and she had to look at each resident's last assessment to make a weekly MDS schedule. Per interview, she was trying to get the assessments done when they were due. However, she did not know what assessments were due now or next week. Interview with the RN Consultant/Owner on 07/15/10 at 2:00 PM, revealed she was not aware of any late assessments, the MDS nurse quit in October 2009, and the facility had experienced computer problems since August 2009. She further stated there was no effective system in place at this time for tracking MDS due dates.	F 273		
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to complete annual resident assessments within the regulatory timeframe of three hundred sixty-six (366) days after final completion of the most recent comprehensive resident assessment for three (3) unsampled residents (Residents A,B, and C).	F 275		

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F 275	Continued From page 6 The findings include: 1. Review of the facility Minimum Data Set (MDS) Transmittal record for Resident A, revealed on 09/02/09, twelve (12) assessments were transmitted to the state data base; three (3) assessments were rejected; and. one (1) annual assessment was transmitted more than three hundred and sixty-six (366) days after the final completion date of the most recent comprehensive assessment. 2. Review of the facility MDS Transmittal record for Resident B revealed on 09/15/09, two (2) assessments were transmitted to the state data base with one (1) annual assessment transmitted more than three hundred and sixty-six (366) days after the final completion date of the most recent comprehensive assessment. 3. Review of the facility MDS Transmittal record for Resident C revealed on 09/16/09, four (4) assessments were transmitted to the state data base with one (1) annual assessment transmitted more than three hundred and sixty-six (366) days after the final completion date of the most recent comprehensive assessment. Interview with the MDS Nurse on 07/15/10 at 1:35 PM, revealed she and/or the owner transmitted the MDS assessments, and she was aware there were late assessments. Per interview the facility was having computer system problems and the MDS Nurse had to look at each resident's last assessment to make a weekly MDS schedule. She stated she was trying to get the assessments done when they were due.	F 275	deleted	

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F 275	Continued From page 7 Interview with the RN Consultant/Owner on 07/15/10 at 2:00 PM, revealed she was not aware of any late assessments, the MDS nurse quit in October 2009, and the facility had experienced computer problems since August 2009. She further stated there was no effective system in place at this time for tracking MDS due dates.	F 275		
F 276 SS=E	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to ensure four (4) of fifteen (15) sampled residents (Residents #5, #11, #13, and #14) and twelve (12) unsampled residents' (Residents E, F, G, H, I, J, K, L, M, N, O, and P) quarterly review assessments were completed within three (3) months (92 days). The findings include: 1. Record review revealed Resident #11 was admitted to the facility on 10/03/07 with diagnosis which included Chronic Kidney Disease, Anemia, Hypertension, and Alzheimer's Disease. Review of the assessments for Resident #11 revealed the last quarterly assessment was completed on 03/22/10, which would make the next assessment due on 06/22/10. Interview with the Minimum Data Set (MDS) Nurse on 07/15/10 at 10:00 AM, revealed the 03/22/10 assessment	F 276		

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F 276	Continued From page 8	F 276		

was the last assessment completed. She stated the next assessment had not yet been completed and she realized it was late. Interview with the Director of Nursing (DON) on 07/15/10 at 11:30 AM, revealed she was the Registered Nurse that signed the assessments when they were completed. She further stated that she was aware the facility was behind on assessments.

2. Record review revealed Resident #5 was admitted to the facility on 02/25/08 with diagnoses which included Depression, Vascular Dementia, Stroke, Epilepsy, Esophageal reflux, Cancer of Rectum, Chronic Obstructive Pulmonary Disease and Aphasia.

Review of the MDS assessments for Resident #5 revealed the last quarterly assessment was completed on 04/09/10, which would make the next assessment due on 07/9/10.

Interview with the MDS Nurse on 07/15/10 at 1:00 PM, revealed the 04/09/10 quarterly assessment was the last assessment completed. She stated the next assessment had not yet been completed and she realized it was late.

3. Record review revealed Resident #13 was admitted to the facility on 02/11/09, with diagnoses which included Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Hypertension, Organic Brain Disease, Osteoporosis, Hypothyroidism, and Mental Retardation.

Review of the MDS assessments for Resident #13 revealed a quarterly assessment was completed on 10/30/09, which would make the next assessment due on 01/30/10. However, the

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F 276	Continued From page 9 next assessment was not completed until 02/17/10, more than ninety-two (92) days later. Interview with the MDS Nurse on 07/15/10 at 1:00 PM, revealed she was aware the assessment was late, she further stated I'm trying to keep up on the assessments. 4. Record review revealed Resident #14 was admitted to the facility on 08/07/07, with diagnoses which include Urinary Tract Infection Sepsis, Diabetes, Dementia, Alzheimer's Disease, and Depression. Review of the MDS assessments for Resident #14 revealed a quarterly assessment was completed on 12/08/09. However, the next assessment was not completed until 03/28/10, more than ninety-two (92) days later. Interview with the MDS Nurse on 07/15/10 at 1:00 PM, revealed she was aware the assessment was late, she further stated I'm trying to keep up on the assessments 5. Review of the facility MDS Transmittal record for Residents E, F, G, H, I, J, K and L revealed on 03/26/10, of the one hundred and twenty-two (122) assessments transmitted to the state data base, eight (8) quarterly assessment were transmitted more than ninety-two (92) days after the final completion date of the most recent assessment. 6. Review of the facility MDS Transmittal record for Resident M revealed on 05/11/10, two (2) assessments were transmitted to the state data base, with one (1) quarterly assessment transmitted more than ninety-two (92) days after	F 276		

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F 276	Continued From page 10 the final completion date of the most recent assessment. 7. Review of the facility MDS Transmittal record for Residents N, O, and P revealed on 06/30/10, seventy (70) assessments were transmitted to the state data base with three (3) quarterly assessment transmitted more than ninety-two (92) days after the final completion date of the most recent assessment. Interview with the Director of Nursing (DON) on 07/15/10 at 11:30 AM, revealed she was the Registered Nurse (RN) who signed the assessments when they were completed. She further stated that she was aware the facility was behind on assessments. Interview with the MDS Nurse on 07/15/10 at 1:35 PM, revealed she and/or the owner transmitted the MDS, and she was aware there were late assessments.	F 276	delete possible S/S "D"	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		

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F 278	Continued From page 11 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure one (1) of fifteen (15) sampled residents (Resident #1) Minimum Data Set (MDS) assessment accurately refected the resident's status. The findings include: Review of Resident #1's clinical record revealed diagnoses which included Dementia with Behaviors, Chronic Renal Failure, Hypertension, and Cardiovascular Accident. Review of the Significant Change MDS assessment dated 12/28/09 revealed Resident #1 was assessed by the facility as experiencing a fall in the past thirty-one (31) to one hundred eighty (180) days. Interview with the Director of Nursing (DON) on 07/15/10 at 11:30 AM revealed Resident #1 experienced a fall on 12/16/10, however the	F 278		

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F 278	Continued From page 12 assessment did not reflect the fall in the past thirty (30) days. The DON stated the MDS Coordinator at the time the Significant Change assessment was completed no longer worked at the facility. She further stated the 12/16/10 fall should have been reflected on Resident #1's assessment.	F 278		
F 280 SS=G	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure Comprehensive Plans of Care were reviewed and/or revised for two (2) of fifteen (15) sampled residents(Resident #1 and #2). The	F 280		

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F 280	Continued From page 13 facility failed to ensure Resident #1's comprehensive care plan and nurse aide care plan were revised to ensure Resident #1 was receiving the appropriate assistance for the resident's care needs as it relates to his/her risk for falls. The facility identified Resident #1 as having a pattern of tripping over obstacles in the environment, which resulted in falls. Resident #1 experienced a fall on 06/23/10 and was sent to the Emergency Department. The hospital discharge diagnosis included multiple facial fractures, acute trauma to the eye and a laceration to the left temple which required sutures. Resident #2's Plan of Care failed to be revised after the development of a pressure sore. The findings include: 1. Record review revealed Resident #1 was admitted to the facility with diagnoses which included Dementia with Behaviors, Chronic Renal Failure, Hypertension, Seizures and Cardiovascular Accident. The Resident Assessment Protocols (RAPS) from a Significant Change Assessment dated 12/28/10 was reviewed and revealed the resident triggered for vision and the resident would not always wear his/her glasses. Falls were triggered due to the resident's history of falls, psychotropic medication use, and the diagnosis of Dementia. The RAP Summary indicated Resident #1 paced the hallways with no regard to safety and the resident transferred his/herself and ambulated without waiting for assistance. The Quarterly Minimum Data Set (MDS) dated 06/14/10 revealed the facility assessed Resident #1 as having an unsteady gait and requiring extensive assist with transfers and ambulation. Review of	F 280		

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F 280	Continued From page 14 the assessment revealed the resident had fallen in the last thirty (30) days and in the last thirty-one (31) to one hundred eighty (180) days. Review of the Comprehensive Plan of Care, developed 12/28/09, updated 03/10 and 06/10, revealed the facility had developed a plan related to Resident #1's risk for falls. Review of the Plan of Care revealed interventions which included to observe the resident's mobility for unsteadiness, review safe use of mobility devices and to attempt to assist the resident with ambulation as needed, non skid socks/shoes, the use of a floor alarm mat (interventions added to the Plan of Care were not dated). However, the Comprehensive Plan of Care did not address the causal factors/risk factors of Resident #1's falls which the facility had identified, environmental factors such as the resident's history of tripping. Record review and interview with the Director of Nursing (DON) on 07/15/10 at 11:00 AM revealed Resident #1 had experienced falls on 12/16/09, 01/21/10, 02/23/10, and 06/10/10 due to Resident #1 independently transferring/ambulating and tripping over obstacles in the environment. The DON revealed the facility had identified Resident #1's pattern of tripping over obstacles in the environment. She stated the intervention related to the use of nonskid socks and shoes were added to the Plan of Care on 06/10/10. The Nurse Aide Flow Sheet/Care Plan, dated June 2010, for Resident #1 revealed under "Mobility" the resident required one or two staff to assist for transfers as well as during ambulation. The plan noted under "Special Instructions" the Nurse Aides were to observe the resident when he/she was up and walking and to encourage the resident to use handrails in the hallway.	F 280		

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F 280	Continued From page 15 Review of Resident #1's clinical record revealed on 06/23/10 at 11:30 PM the resident sustained a fall in the hallway, just outside his/her room. The resident was transported to the local hospital Emergency Room. The Emergency Room Note, dated 06/24/10, revealed the resident presented with a laceration to the left temporal and an injury to the left eye. Review of the hospital discharge summary, dated 06/25/10, revealed discharge diagnoses which included: multiple facial fractures to the eye and sinuses. The summary indicated the resident experienced acute trauma to the eye and a laceration to the left temple which required sutures. Interview, on 07/14/10 at 10:30 AM, with Certified Nursing Assistant (CNA) #2, who cared for Resident #1, revealed having knowledge of the resident's history of wandering and risk for falls. This CNA indicated Resident #1 transferred his/herself and ambulated without assistance. CNA #2 indicated having knowledge of the resident's need for assistance with ambulation/transfers and stated the resident would just get up and "take off". The CNA #2 stated she tried to monitor the resident until he/she (meaning the resident) got to where he/she was going. CNA #2 stated Resident #1 had an unsteady gait and a history of tripping over environmental obstacles. Further interview with the DON revealed that the floor alarm mat was not added to the care plan until on 06/23/10 and Resident #1 was moved to a room located near the Nurses Station for closer supervision after the resident experienced the fall on 06/23/10. However, there was no evidence the facility reviewed/revised the Plan of Care and	F 280		

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F 280	Continued From page 16 the nurse aide care plan to ensure Resident #1 was receiving the appropriate assistance for the resident's care needs as it relates to his/her risk for falls. Furthermore the plan to include an alarming floor mat and moving the resident to a room closer to the nurses statation was not implemented until. Resident #1 experienced a fall in the hallway on 06/23/10 which resulted in a laceration to the left temporal and an injury to the left eye. 2. Resident #2 was admitted to the facility on 12/22/09 with diagnosis which included Schizophrenia, Congestive Heart Failure, and Depression. Review of the Admission MDS assessment dated 01/04/10 revealed the facility assessed the resident as being at risk for pressure sores. Review of the RAPS dated 01/04/10 revealed Resident #1 triggered for being at risk for skin breakdown due to being admitted with a vulvar abscess, yeast rashes, and a Stage I pressure area to the buttocks. Record review revealed Resident #2 developed a pressure sore at the base of the right big toe on 07/05/10. Review of the nurses notes revealed the Physician was notified and a treatment was obtained for the area, which started on 07/06/10. Review of the Comprehensive Care Plan dated 01/11/10 and updated on 04/10 revealed a potential for skin breakdown, however further review revealed no evidence the care plan was revised to include the the development of a new pressure area to the right big toe, which developed on 07/05/10.	F 280		

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F 280	Continued From page 17 Interview with the DON on 07/14/10 at 2:30 PM revealed the care plan should have been revised on 07/05/10 to include the new pressure area. Observation on 07/14/10 at 10:50 AM, during a skin assessment, revealed the pressure area had healed.	F 280		
F 287 SS=F	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: Admission assessment. Annual assessment updates. Significant change in status assessments. Quarterly review assessments. A subset of items upon a resident's transfer, reentry, discharge, and death. Background (face-sheet) information, if there is no admission assessment. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following: Admission assessment. Annual assessment.	F 287		

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F 287	Continued From page 18 Significant change in status assessment. Significant correction of prior full assessment. Significant correction of prior quarterly assessment. Quarterly review. A subset of items upon a resident's transfer, reentry, discharge, and death. Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to electronically transmit encoded, accurate, and complete Minimum Data Set (MDS) data to the state monthly. Review of the facility transmittal reports from September 2009 through June 2010 revealed three hundred and six assessment were transmitted more than 31 days after completion. The facility failed to have an effective system in place to correct this failure. The findings include: Review of the facility transmittal reports from September 2009 through June 2010 revealed three hundred and six (306) MDS assessments transmitted to the state which was more than thirty one (31) days after completion. Interview with the Executive Director and the	F 287		

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F 287	Continued From page 19 Registered Nurse Consultant/Owner on 07/14/10 at 3:45 PM, revealed they were aware the assessments was transmitted late and had no effective system in place for tracking and assuring transmission was completed timely.	F 287		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the residents' environment remained as free of accident hazards as possible. The facility failed to ensure each resident received adequate supervision and assistance to prevent accidents for one (1) of fifteen (15) sampled residents (Resident #1) related to falls. On 06/23/10 the facility assessed Resident #1 as having a history of falls. On 06/23/10 Resident #1 experienced a fall and sustained facial fractures which required sutures. The facility identified causal factors of Resident #1's falls; however, failed to evaluate the effectiveness of interventions established on the resident's Plan of Care. The facility failed to provide assistance as specified on the Nurse Aide Flow Sheet/Care Plan, and failed to follow the facility's "Falls Policy Statement". Additionally, the facility failed to ensure	F 323		

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F 323	Continued From page 20 housekeeping carts, which contained hazardous chemicals, remained locked and/or attended in order to prevent residents access to these chemicals. The findings include: Review of the facility's "Falls Policy Statement:" (no date noted) revealed the facility would assess, monitor, and prevent as possible, resident injuries from falls. 1. Review of Resident #1's clinical record revealed diagnoses which included Dementia with Behaviors, Hypertension, Seizures and Cardiovascular Accident. Review of the Resident Assessment Protocols Summary (RAPS) from a Significant Change Assessment, dated 12/28/09, revealed the facility assessed the resident as having vision impairment and the Summary indicated the resident would not always wear his/her glasses. Review of the RAPS revealed falls triggered due to a history of falls, psychotropic medications, and Dementia. The Summary indicated Resident #1 paced the hallways with no regard to safety, transferred self, and ambulated without waiting for assistance. Review of Resident #1's Quarterly Minimum Data Set (MDS) dated 06/14/10, revealed the facility assessed Resident #1 as having an unsteady gait, requiring extensive assistance with transfers and ambulation and as having experienced falls within the last thirty (30) days and the last thirty-one (31) to one hundred and eighty (180) days. Further review revealed the facility assessed Resident #1 as having bilateral	F 323		

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F 323	Continued From page 21	F 323		

limitations related to range of motion in the arms and legs, as well as, partial loss of voluntary movement.

Review of the Comprehensive Plan of Care, developed 12/28/09, updated 03/10 and 06/10, revealed a plan was developed related to Resident #1's risk for falls. Review of the Plan of Care revealed interventions which included to observe the resident's mobility for unsteadiness, review safe use of mobility devices, and to attempt to assist the resident with ambulation as needed, non skid socks/shoes, the use of a floor alarm mat (interventions added to the Plan of Care were not dated). However, The Comprehensive Plan of Care did not address the causal factors/risk factors of Resident #1's falls which the facility had identified, such as environmental factors related to the resident's history of tripping.

Review of Resident #1's Nurse Aide Flow Sheet/Care Plan, dated June 2010, revealed under "Mobility" the facility had identified the resident required one or two staff to assist related to transfers and ambulation/assistance. Also, the plan noted under "Special Instructions" the Nurse Aides were to observe when the resident was up and walking and to encourage the resident to use handrails in the hallway.

Record review and interview with the Director of Nursing (DON) on 07/15/10 at 11:00 AM, revealed Resident #1 experienced a fall on 12/16/09 in his/her room while independently ambulating and tripped over the bedside table. On 01/21/10 the resident sustained a fall while ambulating in the common room and tripped over another resident's oxygen tubing. On 01/23/10

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F 323	Continued From page 22 and 01/24/10 the resident experienced unwitnessed falls in his/her room. On 02/23/10 Resident #1 fell over another resident's gastrostomy pole in the common room; and on 06/10/10 the resident got out of bed and tripped over a trash can in his/her room. Record review revealed Resident #1 experienced a fall in the hallway, just outside his/her room on 06/23/10 at 11:30 PM. The resident was transported to the local hospital Emergency Room at that time. Review of the Emergency Room Note, dated 06/24/10, revealed the resident presented with a laceration to the left temporal and left eye injury. Review of the hospital discharge summary, dated 06/25/10, revealed discharge diagnoses which included: Multiple facial fractures to the eye and sinuses. The summary indicated the resident experienced acute trauma to the eye and a laceration to the left temple which required sutures. Review of the facility's investigation related to the fall on 06/23/10 revealed Resident #1 walked across the hallway several steps and fell. The investigation indicated the resident's activity prior to the fall as being "ambulates self". The investigation also noted the resident was noncompliant with unassisted ambulation. Interview with the DON on 07/14/10 at 2:50 PM, revealed the resident fell in the hallway right outside of his/her room. The DON stated Resident #1 was moved to a room near the Nurses Station on 06/25/10. During the interview on 07/15/10 at 11:00 AM with the DON, she indicated the facility identified Resident #1 had a pattern of tripping over obstacles in the environment. The DON stated	F 323		

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F 323	Continued From page 23 the intervention for the use of nonskid socks and shoes was added to the Plan of Care on 06/10/10 and the use of a floor alarm mat was added on 06/23/10, after the resident experienced the fall that day. Record review revealed Resident #1 was receiving Physical Therapy (PT) until 02/23/10 when PT was discontinued due to the resident being noncompliant. At that time, the resident was referred to Restorative for ambulation. Review of the Restorative assessment and plan dated 05/10 revealed Resident #1 required an assistive device of a gait belt and assistance of one when walking in the hallway, during Restorative. Interview, on 07/14/10 at 10:30 AM, with Certified Nursing Assistant (CNA) #2, who cared for Resident #1, revealed Resident #1 was a wanderer and a falls risk. CNA #2 indicated Resident #1 got in and out of the bed frequently and ambulated back and forth from his/her room and the dayroom, per self. Interview further revealed the resident had an unsteady gait and had a history of tripping over environmental obstacles. CNA #2 indicated awareness of the resident's need for assistance with ambulation and transfers and stated the resident would just get up and "take off". The CNA stated she tried to monitor the resident until he/she (meaning the resident) got to where he/she was going. Observation of Resident #1 on 07/13/10 at 11:55 AM, revealed the resident was in a low bed with the right side of the bed placed against the wall. The left side of the bed had a one half side rail at the top. A pressure alarm mat was noted on the floor beside the bed. Resident #1 was observed	F 323		

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F 323	Continued From page 24 during the survey to be in the bed, with an IV antibiotic running. 2. On 07/13/10 at 11:30 AM, an unlocked, unsupervised, and open housekeeping cart was observed in the hall between rooms 114 and 302. Further observation revealed items in the unlocked section of the housekeeping cart included Tropic Breeze Metered Air Freshener, which according to MSDS if ingested "may cause central nervous system disorder and/or damage," and Springtime, a deodorant that according to MSDS if ingested "may cause nausea, vomiting, and diarrhea." An interview with Housekeeper #1 on 07/13/10 at 5:30 PM, revealed she was assisting another housekeeper with "deep cleaning" a resident room. Housekeeper #1 stated that the housekeeper she was assisting had the key to the housekeeping cart, and may not have locked it as she was sharing the cart. An interview with the Maintenance Director on 07/14/10 at 8:35 AM, revealed housekeeping carts should be locked when not attended by a housekeeper.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEMONT HEALTHCARE	323 WEBSTER AVENUE CYNTHIANA, KY 41031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by scoops stored improperly, dented cans stored for use, and staff not wearing hair nets to fully cover all hair in kitchen area, not washing their hands properly during tray line, and going from dirty to clean without washing their hands while using the dish washer. The findings include: 1. Observation on 07/13/10 at 11:52 AM, revealed during tray line the cook went to the refrigerator, removed a container of mechanical sandwiches, returned to the tray line and continued to serve the tray line without removing the gloves and washing hands. At 12:02 PM she went back to the refrigerator and removed ham and bread for sandwiches; she removed her gloves; did not wash her hands and put new gloves on; and, continued the tray line. At 12:15 PM observation revealed the cook portioned ravioli into a bowl; picked a rag up off the stove; wiped the side of the bowl; and, continued the tray line which included picking up bread, tomatoes and lettuce with her gloved hand. Further observation of the tray line revealed two (2) dietary aides pushed two (2) food carts out to the floor, and returned to the tray line without washing their hands. Interview with the Cook #11 on 07/13/10 at 12:25 PM, revealed she should have removed her gloves each time she left the tray line and washed	F 371		

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F 371	Continued From page 26 her hands before putting gloves back on. She further stated the rag was not clean and should not have been used and she should have washed her hands before continuing the tray line. Interview with the Dietary Aide #9 on 07/13/10 at 12:30 PM, revealed the facility procedure was to wash your hands when you return to the kitchen from transporting tray carts. She further stated she should have washed her hands. 2. Observation on 07/13/10 at 9:42 AM, revealed three (3) dietary staff employees in the kitchen with improper hair covering. The cook had long strands of hair which were loose from the back of the hair covering. Dietary Aide #9 had long strands of hair on each side of her face. Dietary Aide #13's hair appeared to be up in a bun under the hair covering, but the covering did not cover the front or back of her hair. Interview with Cook #11 on 07/13/10 at 12:25 PM, revealed staff did not cover hair properly most of the time. She further stated hair should be covered in the kitchen to prevent contamination of food and food items. 3. Observation on 07/13/10 at 9:15 AM, revealed scoops were stored in a drawer with handles turned opposite ways and scoops were not stored down. Interview with Cook #11 on 07/14/10 at 1:00 PM, revealed she was aware the scoops were not stored properly, she further stated the handles should all be turned the same way and the scoops turned down. 4. Observation on 07/13/10 at 9:15 AM, of the dry	F 371		

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F 371	Continued From page 27 storage area revealed five (5) dented cans mixed in with stored canned foods for use (Tapioca pudding, tomato sauce, french style green beans, diced tomatoes and beef broth). Interview with the Dietary Manager on 07/14/10 at 9:00 AM, revealed she was responsible for putting food orders away when received and the procedure for dented cans was to set them aside and call the food supplier to pick up the dented cans. She did not have a specified area for dented cans. She further stated she did not know why dented cans should not be used. 5. Observation of the dish line on 07/13/10 at 9:42 AM, revealed Dietary Aide #11 pushed a rack of dirty dishes into the dish washer and went to the clean side and put the clean dishes away without washing her hands. Interview with the Dietary Aide #11 on 07/14/10 at 10:00 AM, revealed the facility procedure for the dish line was one person to do the dirty side and one person to do the clean side. She further stated I should have washed my hands before going to the clean dish side.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		

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F 441	Continued From page 28 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure infection control practices were maintained by accepted professional practice during care for one (1) of fifteen (15) sampled residents (Resident #4). The finding include: Observation of wound care on 07/17/10 at 9:10 AM, revealed Registered Nurse (RN) #1 was	F 441		

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F 441	Continued From page 29 preparing to do wound care on Resident #4's left posterior thigh/lower buttock when it was found Resident #4 was soiled. Observation revealed RN #1 removed the soiled brief, provided perineal care to Resident #4, and then continued with wound care. Observation revealed RN #1 failed to remove the soiled gloves, wash her hands, and don clean gloves after perineal care and prior to doing wound care. Interview with RN#1, on 07/17/10 after wound care, revealed Resident #4 should have been cleaned and changed prior to the wound care. She stated she should have removed her gloves, washed her hands, and applied clean gloves before continuing the wound care.	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the	F 520		

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F 520	Continued From page 30 requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure Quality Assessment and Assurance Committee developed and implemented appropriate plans of action to correct identified quality deficiencies related to 483.20 Resident Assessment. The findings include: Review of the facility resident assessment transmittal records from September 2009 through June 2010 revealed the facility failed to complete Minimum Data Set assessments in a timely manner. Residents' Admission assessment failed to be completed in fourteen (14) days after admission. Residents' MDS assessment were found to be more than ninety two (92) days after last quarterly assessment and more than three hundred and sixty six (366) days after last Comprehensive assessment. The facility also transmitted three hundred and six (306) resident assessments more than thirty one (31) days after completion. Interview with the Executive Director and the Registered Nurse Consultant/Owner on 07/14/10 at 3:45 PM, revealed they were aware the assessments was transmitted late and had no effective system in place for tracking and assuring transmission was completed timely.	F 520		

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